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## Letter to the Editor

# The Single Shared Electronic Patient Record (SSEPR): problems with functionality and governance

Dear Editor,

The GP Electronic Patient Record (GP-EPR) is undoubtedly one of the success stories in general practice in the UK.

Since I came into practice in 1979, GP records have gone from being paper-based in Lloyd George envelopes (approximately A5 size cardboard record envelopes) to highly computerised and structured records, with a corresponding revolution in their usefulness – and purposes to which they can be put: who would have dreamed of QOF (Quality and Outcome Framework: introduced in the new GMS contract in 2003 to measure quality of care for selected chronic conditions in general practice, for performance related pay. It depends on entering information into the GP computer system) and QMAS (The Quality Management and Analysis System, known as QMAS, is a national IT system which gives GP practices and Primary Care Trusts (PCTs) objective evidence and feedback on the quality of care delivered to patients. It supports the Quality and Outcomes (QOF) element of the GP contract and has been in operation since 2004. www.connectingforhealth.nhs.uk/systemsandservices/gpsupport/qmas) in 1979?

This sea-change in record keeping was driven both by enthusiasts who could see the potential for patient care – and successive governments who could see possibilities as well.

I am becoming increasingly concerned about the future of this success story. One of the requirements in NPfIT (the English NHS National Programme for Information Technology) is for a single electronic medical record for every patient, used and contributed to by all healthcare professionals involved in the care of that patient. Let's call this new record the SSEPR to differentiate if from the Summary Care Record held by the Personal Spine Information Service (PSIS) (The Spine. www.carelink.co.uk/upload/Documents/Collateral/ spine_factsheet.pdf) and the Detailed Care Record (DCR) which is yet to be precisely defined but may be similar to the SSEPR.

Current examples are CSC/TPP SystmOne (Clinical Science Partnership/The Phoenix Partnership) for primary care and in the near future Lorenzo, which is planned (presentation by CSC at the East of England event 'Improving Lives Saving Lives – the future of NPfIT' 6/12/07 http://etdevents.connectingforhealth.nhs.uk/1307 PowerPoint by Simon Holt) apparently, to include hospital, GP and community records.

Looking at the only functioning model (CSC/TPP SystmOne), there would seem to be a lack of agreement about both the functions of the record and its governance. Leaving aside the very important issues of access and consent – the Caldicott Guardian and Data Controller aspects – at present only the organisation entering data (which includes prescriptions) can change it. There are already cases where community staff – whose record keeping needs are totally different from those of GPs and whose training does not include managing comprehensive patient records – have put in diagnoses which are erroneous, but cannot be corrected by the GP. Reported cases include diabetes mellitus and multiple sclerosis – both of which have serious adverse implications for both patient management and life insurance.

Hospital records are more similar to community than to GP records, being at present largely narrative and based on episodes of single problems. Hospital doctors, like community staff, have had no tradition of clinical coding, especially with Read or its successor SNOMED-CT, and have less requirement for the complex comprehensive records we maintain in general practice.

I am unconvinced that the SSEPR is usable in real life. The fundamental issues are: who can read, who can enter and who can alter erroneous data entered in a different organisation. Prescribing, by its very nature, will need to be changed by individuals not in the same organisation.

In the circumstances, I have asked the NPSA (National Patient Safety Agency) to put the SSEPR on their IT Risk Register and have circulated my report to everyone I can think of; my SHA (East of England Strategic Health Authority), CSC/TPP, my PCT (Bedfordshire Primary Care Trust), the British Medical Association, JPGITC and the Office of the Information Commissioner.

Everyone says they are taking it seriously, but SystmOne GP/community is still being pushed in NME (North, Midlands and East – the old North East, North West and East and East Midlands NHS Clusters – where CSC is the LSP: contracts are different in the three clusters – but details are commercially confidential) – the clusters in which CSC is the Local Service Provider – and the information does not appear to have been passed to the SHA and PCT staff implementing the shared record, let alone the GPs potentially affected!

*Is* the SSEPR possible – or desirable – and if it is implemented under current plans, does this mean the end of the GP-EPR, QOF and QMAS as measures of practice performance?

Dr Mary Hawking

Since this letter was submitted, a competitive contract notice has been posted on www.supply2.gov.uk

UK–LEEDS: SHARED RECORD PROFESSIONAL GUIDANCE SERVICE
Entry Date: 21/05/2008
Reference: S2G08052158785/01
This work package will establish professional shared records keeping guidelines for the management of information and responsibility for patient care in a shared record system, assured by multi-professional and patient bodies. The principles of these deliverables should be applicable across all shared record settings.